AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155303	A. BUIL	DING	ONSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEI AMARITAN SOCIE	R TY SHAKAMAK RETIREMENT CC)MN		DHIO ST VILLE, IN47438		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
,	This visit was fo	or a Recertification and	F0	000			
	State Licensure						
		3					
	Survey Dates: April 12, 13, 14, 15, & 18,						
	2011						
	Facility Number	- 000200					
	Provider Number						
	AIM Number: 1						
	7 HIVI TVUIIIOCI.	100307700					
	Survey Team:						
	Mary Weyls RN	TC					
		RN (April 12 and 13,					
	2011)	Kiv (71piii 12 and 13,					
	Teresa Buske Ri	NI.					
	Teresa Buske Ki	N					
	Census Bed Typ	e:					
	SNF/NF: 54						
	Total: 54						
	10001. 0						
	Census by Payor	r Source:					
	Medicare: 6						
	Medicaid: 38						
	Other: 10						
	Total: 54						
	10tui. 5T						
	Sample: 14						
	These deficienci	ies also reflect state					
	findings cited in	accordance with 410 IAC					
	16.2.						
	· - ·						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U57U11

TITLE

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155303	B. WIN			04/18/20	011
			P. (112)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OHIO ST		
	AMARITAN SOCIET	TY SHAKAMAK RETIREMENT C	OMN				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	'	/25/11 by Suzanne					
	Williams, RN						
F0323	-	nsure that the resident					
		ins as free of accident sible; and each resident					
	receives adequate						
	assistance devices to prevent accidents.						
SS=D	Based on observation, interview, and record review, the facility failed to ensure		F0	323	Credible allegation of Compliance	e [04/29/2011
					And Correction		
	the resident envir	ronment remained free of				,. l	
	accident hazards.	in that staff failed to			Submission of this plan of correct shall not constitute or be construed.		
		arer's guidelines for the			as an admission by The Evangelia		
		rsonal alarms used for the			Lutheran Good Samaritan Society		
	- ' '	ls, for 2 of 3 residents			Shakamak Retirement Communit		
	observed utilizing				that the allegations contained in t		
	l '	n a sample of 14.			survey report are accurate or refle		
	1 ^	•			accurately the provision of service	e to	
	(Resident # 11, R	tesident #44)			the residents of Shakamak Retirement Community.		
	Findings include						
		•			What corrective action (s) will b		
	1 On 4/13/11 at	10:50 a.m., Resident #			accomplished for those residents		
		to be sitting in a personal			found to have been affected by t deficient practice;	ine	
		agnetic clip personal			denotes practice,		
	alarm applied. The				F323 FREE OF ACCIDENT		
		tting on the arm of the			HAZARDS/SUPERVISION/DEV	VIC	
		•			ES		
		On 4/14/11 at 2:05 p.m.,			Danidant #44 41 11 1		
		observed to be sitting in			Resident #44, the clip alarm was secured immediately by the DNS		
	_	iner with a magnetic clip			secured miniculatory by the DNS		
	l ⁻	oplied. The alarm box			Residnet #11, the alarm was		
		be on top of the cushions			changed to a pressure pad alarm		
		nt's head, unsecured. On			which did not require same guide	line	
		at 10:50 a.m., the resident was			for securing.		
		tting in her personal			H		
	recliner with a m	agnetic clip personal			How other resident having the potential to be affected by the		
	alarm applied. Tl	ne alarm box was			potential to be affected by the		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155303	A. BUI	LDING	00	04/18/2011
		195505	B. WIN			04/10/2011
NAME OF J	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
COOD C	AMADITAN COCIE		ON 4N	1	OHIO ST	
GOOD S	AMARITAN SOCIE	TY SHAKAMAK RETIREMENT C	OIVIIV	JASON	IVILLE, IN47438	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
		n top of the cushions			same deficient practice will be identified and what corrective	
	above the resider	nt's head, unsecured.			faction (s) will be taken:	
					laction (s) will be taken.	
	Review of the clinical record of Resident				All residents have the potential to	be
	#11 on 4/14/11 a	t 2:15 p.m. indicated the			affected by such deficient practice	e.
	resident had a his	story of falls with the			In an effort to identify any concer	rns
	most recent fall of	on 12/22/10 from the			the DNS on 4/15/11 did a visual	
	recliner. The res	ident's current plan of			check on all clip alarmed resident	
		e problem of risk for			ensure compliance with manufact guidelines. Charge nurses were a	
		•			instructed to ensure proper alarm	150
	injury related to osteoporosis, arthritis, unsteady dated 8/25/10, with approaches				usage. All staff were in-serviced	in
	I				the necessity to attach the alarm b	
	that included, but were not limited to,				per the manufacturers guidelines.	
	alarm clip to bed	and chair.			This in service was completed by	
					4/29/11.	
					What measures will be put into	
					place or what systemic changes	
					will be made to ensure that the	
					deficient practice does not recur	:
					The DNS will conduct an audit of	
					resident chairs to identify chairs t	
					do not have a way to attach the al	arm
					per the manufactures guidelines.	_
					DNS or her designee will create a attachment point to secure the ala	
					box per the manufactures guideling	
					As per inservice all staff was	
					instructed to notify the charge nur	rse
					if any unsecured alarms are found	
					The charge nurse shall be respons	
					to audit for placement of alarms p	
					manufactures guidelines 4 times p	•
					shift for 2 weeks, then 2 times per shift for 2 weeks, and then once p	
					shift on going. Any non-complia	
					will be brought to the immediate	
					attention of the DNS and could be	e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	ILDING 00		COMPLETED	
		155303	B. WIN			04/18/20	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			l	OHIO ST		
GOOD S	AMARITAN SOCIET	TY SHAKAMAK RETIREMENT CO	MN	1	NVILLE, IN47438		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
					subject to corrective action.		
					How the corrective action will b		
					monitored to ensure the deficien		
					practice will not recur, i.e., wha quality assurance program will		
					put into place;		
					As a means of quality assurance	a	
					summary of the DNS (or designed	ees)	
					audit of ongoing compliance shall	ll be	
					reported to the Quality Assurance		
					Committee for review on a month	hly	
					basis.		
					Completion Date: 4/29/11		
SS=D	2. Resident #44'	s clinical record was			Credible allegation of Compliance	:e	04/29/2011
	reviewed on 4/14	1/11 at 2 p.m.			And Correction		
					Submission of this plan of correc	tion	
	•	care was noted, dated			shall not constitute or be construct	ed	
	3/31/11, identify	ing "Risk for injury R/T			as an admission by The Evangeli	cal	
	[related to] decre	ased strength HX			Lutheran Good Samaritan Societ		
	[history of falls]	Osteoporosis			Shakamak Retirement Communi		
	Parkinsons." An	intervention was noted			that the allegations contained in t		
	of, but not limite	d to			survey report are accurate or refle		
	bed and chair ala				accurately the provision of service the residents of Shakamak	ie 10	
	oca ana chan ara	.11115.			Retirement Community.		
	Resident #44 was	s observed on 4/14/11 at					
	2 p.m., sitting in	a recliner in the west			What corrective action (s) will be		
	-	larm was attached to the			accomplished for those resident		
		arm box was not attached,			found to have been affected by the deficient practice;	ine	
		*			deficient practice,		
	_	n the top of the recliner.			F323 FREE OF ACCIDENT		
		:05 a.m., resident #44			HAZARDS/SUPERVISION/DE	vic	
	_	ecliner in the west lounge			ES		
	•	n was attached to the					
	resident. The ala	rm box was not attached,			Resident #44, the clip alarm was		
					secured immediately by the DNS	,	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00	N (X3) DATE SURVEY COMPLETED
155303 A. BUILDING B. WING	04/18/2011
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT COMN STREET ADDRESS, CTI 800 E OHIO ST JASONVILLE, IN4	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CO	VIDER'S PLAN OF CORRECTION DIRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
and was sitting on the arm of the recliner. The manufacturer's recommendation, titled "Personal Sentry Patient Protector with Safety-Klip," was received on 4/15/11 at 4:55 p.m. from the DON (Director of Nursing). The information indicated the alarm has a metal mounting clip on the back of the unit. During interview of the DON on 4/15/11 at 4:55 p.m., the DON indicated the alarm box should have been secure causing the alarm to detach as soon as the resident attempted to get up. 3.1-45(a)(2) All reside affected be no ensure conguidelines instructed usage. A the necess per the marchis in se 4/29/11. What mee place or v will be may deficient to DNS or he attachmen box per the marchis in structed to so per the not per the marchis in se instructed to so per the not per the marchis in se instructed to so per the not per the marchis in se instructed to so per the marchis in se instructed to so per the marchis in se instructed to so per the nate the necess to per the marchis in se instructed to so per the nate the necess to per the marchis in se instructed to so per the nate the necess to per the marchis in se instructed to so per the nate the necess to per the nate that the nate	#11, the alarm was o a pressure pad alarm not require same guideline

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/04/2011 FORM APPROVED OMB NO. 0938-0391

	PLAN OF CORRECTION DESCRIPTION STREET OF THE PROVIDER/SUPPLIER/CLIA		A. BUILDING 00			COMPLETED 04/18/2011	
		155303	B. WIN			04/18/2	U11
	PROVIDER OR SUPPLIER	TY SHAKAMAK RETIREMENT CC) MN	800 E C	ADDRESS, CITY, STATE, ZIP CODE DHIO ST VILLE, IN47438		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0334	The facility must deprocedures that erection in the procedures that erection is and procedure in the benefits and procedure in	levelop policies and insure that the influenza immunization, he resident's legal eives education regarding otential side effects of the s offered an influenza ober 1 through March 31 ine immunization is dicated or the resident has unized during this time r the resident's legal is the opportunity to refuse			The charge nurse shall be respons to audit for placement of alarms produced to a place and the place of the shift for 2 weeks, then 2 times pershift on going. Any non-compliance will be brought to the immediate attention of the DNS and could be subject to corrective action. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will put into place; As a means of quality assurance assummary of the DNS (or designed audit of ongoing compliance shall reported to the Quality Assurance Committee for review on a month basis. Completion Date: 4/29/11	per	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155303		LDING	NSTRUCTION 00	(X3) DATE COMP 04/18/2	LETED
	PROVIDER OR SUPPLIER	II R TY SHAKAMAK RETIREMENT C	<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE OHIO ST VILLE, IN47438	.	
GOOD S (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR documentation the following: (A) That the resi representative was regarding the beneffects of influenza (B) That the resi influenza immunizi influenza immunizi contraindications The facility must of procedures that efficiency of the facility must of the facili	ETATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) at indicates, at a minimum, dent or resident's legal is provided education efits and potential side a immunization; and dent either received the exation or did not receive the exation due to medical or refusal.	COMN	1		.D BE	(X5) COMPLETION DATE
	legal representation regarding the beneffects of the immunity (ii) Each resident immunization, unlimedically contrain already been immunization; and (iv) The resident's documentation that following: (A) That the resimpresentative was regarding the beneffects of pneumonical contrain (v) As an alternation assessment and precommendation,	ve receives education efits and potential side unization; is offered a pneumococcal ess the immunization is idicated or the resident has innized; or the resident's legal is the opportunity to refuse d medical record includes at indicated, at a minimum, dent or resident's legal is provided education efits and potential side acoccal immunization; and dent either received the munization or did not inococcal immunization due indication or refusal. ve, based on an oractitioner a second pneumococcal or be given after 5 years pneumococcal					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		ONSTRUCTION 00	(X3) DATE S COMPL	ETED
		155303	B. WIN	G		04/18/2	011
	PROVIDER OR SUPPLIER	TY SHAKAMAK RETIREMENT CO	MN	800 E C	ADDRESS, CITY, STATE, ZIP CODE DHIO ST VILLE, IN47438		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
SS=B	contraindicated or resident's legal resecond immunizate Based on record facility failed to a medical record in that the resident and potential side and/or pneumococof 14 residents id offered the influe pneumococcal in sample of 14. (Re 25, Resident # 44 Findings include 1. Review of the Resident #18 on indicated the resignifluenza immunicated the resignifluenza immunicated the resignifluenza immunicated influenza immunicated influenza immunicated influenza immunicated documentation of representative before influenza immunicated documentation of RN a.m. indicated docume	the resident or the presentative refuses the gion. The review and interview, the ensure each resident's included documentation for resident's legal ere provided the benefits effects of the influenza occal immunizations for 4 dentified receiving or enza and/or immunizations in a resident #18, Resident #4, Resident #55) Example 11:05 a.m. dent received the dentified exercived the dentified exercived the dentified received the dentified received the dentified received the dentified received the dentified exercised exercis	FO	TAG 334	Credible allegation of Compliance And Correction: Submission of this plan of correct shall not constitute or be construe as an admission by The Evangelic Lutheran Good Samaritan Society Shakamak Retirement Communit that the allegations contained in the survey report are accurate or refles accurately the provision of service the residents of Shakamak Retirement Community. F334 Influenza and Pneumococci immunizations: What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; Resident # 44 legal representative was provided education on 4/29/1 and received the pneumococcal immunization. Resident # 44 legar representative will receive education annual flu immunization by 10/2010. Resident #55 (per the 2567, I thin resident #53 per the numbered rose	cion d cal y y nis cct e to al e s he l ion	04/29/2011
	aware of the bendeffects of the infl lacking. The RN	epresentative being made efits and potential side uenza immunization was indicated information luenza immunization was			as indicated by the fact that this resident was a truck driver) legal representative provided education 4/29/11 and received the pneumococcal immunization.		

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155303	B. WIN			04/18/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
00000	AAAADITAN OOGIFT	DV OLIAKANAN DETIDEMENT O	20.40		OHIO ST	
GOOD S.	AMARITAN SOCIET	TY SHAKAMAK RETIREMENT CO	JIVIIV	JASON	IVILLE, IN47438	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	sent to the legal r	•			Resident # 18 legal representative will be provided education prior t	
	September of 2010.				annual flu immunization by 10/20	
					amuai na mimamzation by 10/20	,11.
	2. Review of the clinical record of				Resident # 25 legal representative	,
	Resident #25 on	4/13/11 at 11:30 a.m.			will be provided education prior t	
	indicated the resi	dent received the			annual flu immunization by 10/20)11.
	influenza immun	ization on 12/6/10.				
	Documentation of	of the resident's legal			How other resident having the	
		eing made aware of the			potential to be affected by the same deficient practice will be	
	•	ntial side effects of the			identified and what corrective	
influenza immunization was lacking.					faction (s) will be taken:	
	influenza influenzation was lacking.					
	Interview of RN	#3 on 4/18/11 at 10:55			All residents have the potential to	
		cumentation of the			affected. All residents will receiv	
					annual flu and pneumococcal vac education. No negative outcomes	
	_	epresentative being made			noted due to the deficient practice	
		efits and potential side			lioted due to the deficient practice	
		uenza immunization was			What measures will be put into	
	_	indicated information			place or what systemic changes	
		luenza immunization was			will be made to ensure that the	
	sent to the legal r	•			deficient practice does not recur	:
	September of 20	10.			RN/LPN will provide annual	
					flu/pneumonia vaccine education	
					prior to giving immunizations.	
					Residents refusing vaccines in the	·
					past will be given education and	
					given the opportunity to accept or	
					refuse the immunization on an an basis.	nual
					Uasis.	
					How the corrective action will be	e
					monitored to ensure the deficien	
					practice will not recur, i.e., what	
					quality assurance program will	be
					put into place;	
					HIM Director will report audits to	,
					This Director will report addits to	, <u> </u>

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155303		A. BUII	LDING	00	(X3) DATE S COMPL 04/18/2 (ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE DHIO ST VILLE, IN47438	1, 10,2	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
SS=B	An admission da Documentation to received and/or viand/or pneumonia Documentation to resident or legal received education potential side efficiency on 4/18 During interview Nursing) on 4/18 DON indicated the been approached vaccinations, and the resident had in	te of 1/30/11 was noted. o indicate resident #44 was offered an influenza a vaccine was lacking. o indicate that the representative had on regarding benefits and ects of vaccination was of the DON (Director of //11 at 2:45 p.m., the ne resident's wife had			QA committee annually every November on all residents flu/pneumonia vaccine statuses. will include monitoring that education was given prior to vaccination and that those who previously had refused received education and were given the opportunity to accept or refuse again. If not 100% compliant QA committee will make further recommendations. Completion Date: 4/29/11 Credible allegation of Compliance And Correction: Submission of this plan of correct shall not constitute or be construct as an admission by The Evangelic Lutheran Good Samaritan Society Shakamak Retirement Community that the allegations contained in t survey report are accurate or reflect accurately the provision of service the residents of Shakamak Retirement Community. F334 Influenza and Pneumococcu immunizations: What corrective action (s) will be accomplished for those residents found to have been affected by to deficient practice; Resident # 44 legal representative was provided education on 4/29/2 and received the pneumococcal immunization. Resident # 44 legal	e tion ed cal y, y, his ect e to al	04/29/2011

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Event ID:

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Facility ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155303	B. WIN			04/18/2011
		<u> </u>	F		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	t .			OHIO ST	
GOOD S	AMARITAN SOCIE	TY SHAKAMAK RETIREMENT CO	OMN.	1	VILLE, IN47438	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	,	DATE
	provided that inf	ormation.			representative will receive education annual flu immunization by	tion
					10/2010.	
		s clinical record was			10/2010.	
	reviewed on 4/18/11 at 11:55 a.m.				Resident #55 (per the 2567, I thin	nk is
					resident #53 per the numbered ro	oster
	An admission date was noted of,				as indicated by the fact that this	
	10/15/10.				resident was a truck driver) legal	
					representative provided education	n on
	Documentation i	ndicated the resident			4/29/11 and received the	
	received a influenza vaccine on 10/27/10				pneumococcal immunization.	
	received a influenza vaccine on $10/27/10$				Resident # 18 legal representative	e
	December 1				will be provided education prior	
	Documentation concerning whether the				annual flu immunization by 10/2	
		eived a pneumococcal			•	
	vaccination was	lacking.			Resident # 25 legal representative will be provided education prior	
	During interview	of the DON on 4/18/11			annual flu immunization by 10/2	011.
	at 2:45 p.m., the	DON indicated the			How other resident having the	
	resident's family	had been contacted and			potential to be affected by the	
	they were not su	re if the resident had ever			same deficient practice will be	
	received a pneur	nococcal vaccination.			identified and what corrective	
	The family indic	ated the resident had been			faction (s) will be taken:	
	l -	d was on the road a lot.				
		ted the family was going			All residents have the potential to	
	to look into it.	the the ranning was going			affected. All residents will receive	
	to look into it.				annual flu and pneumococcal vac education. No negative outcome	
	The facility mali-	ny idantifiad as prior			noted due to the deficient practic	1
		cy, identified as prior			pruotice and the same pruotice	
		uary 2007 and the			What measures will be put into	
	effective date of				place or what systemic changes	
	December 2010, titled "Immunization				will be made to ensure that the	
		eived on 4/8/11 at 4:25			deficient practice does not recu	r:
	p.m. from RN#3				RN/LPN will provide annual	
	The policy indic	ated documentation will			flu/pneumonia vaccine education	,
	indicate that the	resident and or legal			prior to giving immunizations.	•
	representative ha	as received education			Residents refusing vaccines in th	e

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155303		LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED
	PROVIDER OR SUPPLIER	TY SHAKAMAK RETIREMENT CO	OMN	800 E C	ADDRESS, CITY, STATE, ZIP CODE DHIO ST VILLE, IN47438		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	REGULATORY OR	ts and potential side			past will be given education and given the opportunity to accept or refuse the immunization on an arbasis. How the corrective action will to monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will put into place; HIM Director will report audits to QA committee annually every November on all residents flu/pneumonia vaccine statuses. will include monitoring that education was given prior to vaccination and that those who previously had refused received education and were given the opportunity to accept or refuse again. If not 100% compliant Qaccommittee will make further recommendations. Completion Date: 4/29/11	or nnual oe nt nt ot be o	